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BEFORE THE
PHYSICIAN ASSISTANT COMMITTEE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **TAMLIN CONNEL SANTOS, P.A.** 101 Alma Street, Suite 1007 Palo Alto, CA 94301 Physician Assistant License No. PA 16171 Respondent.	Case Nos. 1E-2007-186635; 1E-2008-195356 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Elberta Portman (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Physician Assistant Committee, Department of Consumer Affairs.

2. On or about December 6, 2001, the Physician Assistant Committee issued Physician Assistant License Number PA 16171 to Tamlin Connel Santos, P.A. (Respondent). The Physician Assistant License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Physician Assistant Committee (Committee), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 3527 of the Code states:

"(a) The committee may order the . . . suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license after a hearing as required in Section 3528 for unprofessional conduct which includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the committee or the board.

". . .

"(f) The committee may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license."

5. Section 3502, subdivision (a), of the Code provides, in part, "Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations of the board when the services are rendered under the supervision of a licensed physician and surgeon . . . ."

6. Section 3502.1 of the Code states:

"(a) In addition to the services authorized in the regulations adopted by the board, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon . . ., a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

"(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

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"(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare or adopt a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. The drugs listed shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

"(b) "Drug order" for purposes of this section means an order for medication which is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

"(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician before it is filled or carried out.

"(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

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"(2) A physician assistant may not administer, provide or issue a drug order for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for the particular patient.

"(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

"(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and phone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant. The requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

"(e) The medical record of any patient cared for by a physician assistant for whom the supervising physician and surgeon's drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven days.

"(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA)."

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7. California Code of Regulations (CCR), title 16, section 1399.521 states:

"In addition to the grounds set forth in section 3527, subdivision (a), of the Code, the committee may . . . suspend, revoke or place on probation a physician assistant for the following causes:

"(a) Any violation of the State Medical Practice Act which would constitute unprofessional conduct for a physician and surgeon.

"(b) Using fraud or deception in passing an examination administered or approved by the committee.

"(c) Practicing as a physician assistant under a physician who has been prohibited by the division or the Osteopathic Medical Board of California from supervising physician assistants.

"(d) Performing medical tasks which exceed the scope of practice of a physician assistant as prescribed in these regulations."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Section 2238 of the Code states: "A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

10. Section 2242, subdivision (a), of the Code provides in part, "Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

11. Section 4022 of the Code states: " 'Dangerous drug' . . . means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

". . .

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"(c) Any other drug . . . that by federal or state law can be lawfully dispensed only on prescription . . . ."

12. Section 2234 of the Code states:

"The [Medical Board of California (Board)] shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

". . .

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

". . .

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon" constitutes unprofessional conduct."

". . . ."

13. Section 2234 of the Code provides in part that the Board "shall take action against any licensee charged with unprofessional conduct. . . ." Unprofessional conduct under Section 2234 includes conduct that breaches the rules or ethical code of the medical profession, or conduct that is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.[1]

CONTROLLED SUBSTANCES AND DANGEROUS DRUGS

14. Alprazolam is a Schedule IV controlled substance. (Health & Saf. Code §11057, subd. (d)(1).)

15. Zolpidem is a Schedule IV controlled substance. (Health & Saf. Code §11057, subd. (d)(32).)

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[1] *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.

16. Testosterone cypionate is a Schedule III controlled substance. (Health & Saf. Code §11056, subd. (f)(30).)

17. Promethazine with codeine is a Schedule V controlled substance. (Health & Saf. Code §11058, subd. (c).)

18. Erythromycin is a dangerous drug. (Bus. & Prof. Code §4022, subd. (c).)

COST RECOVERY

19. Section 125.3, subdivision (a) of the Code provides, in part, "Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department . . . upon request of the entity bringing the proceeding the administrative law judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case."

FIRST CAUSE FOR DISCIPLINE

(Practicing Medicine without a Supervising Physician)

20. Respondent is subject to disciplinary action under Code section 3527, subdivision (a), as defined by sections 3502, subdivision (a), 3502.1, subdivisions (a), (c)(1) and (c)(2), and CCR title 16, section 1399.521, subdivision (d), in that she practiced medicine without a supervising physician by prescribing dangerous drugs and Schedule II through V controlled substances. The circumstances are as follows:

21. From about 2005 to about 2008, Respondent occasionally worked for Coastal Dermatology and Southland Surgical. She did not have a Delegation of Services Agreement with physicians at either facility. At the same time, Respondent was working for Imetrikus, Inc., a medical data research business that stored patient records online for subscribing physicians. The only physician who worked for Imetrikus was a Dr. TB. Respondent and Dr. TB compiled data for the company. Imetrikus was not in the patient care business. Respondent did not have a Delegation of Services Agreement with Dr. TB.

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Patient TT

22. In about June 2007, patient TT, a 22 year old man, began a six-month, inpatient alcohol treatment program, pursuant to a court order, at Morningside Recovery Treatment Services (Morningside) in Newport Beach, California. At the time, TT was separated from his wife and young daughter.

23. Part of the Morningside program required TT to attend weekly Alcoholics Anonymous (AA) meetings. Sometime in the summer or early fall of 2007, TT met Respondent at an AA meeting. Thereafter, Respondent began to socialize with TT, and visited him in his room at Morningside, which was against the program's rules. On one occasion, TT was invited to the apartment of his former roommate at Morningside and Respondent accompanied him. At the apartment, Respondent referred to herself as a "doctor." At a later time, the former roommate learned TT was drinking again. TT told his former roommate Respondent was giving him Xanax and injecting him with steroids or hormones to make him bigger.

24. In about November 2007, the Morningside program decided TT could complete the program as an outpatient. TT left the program and moved in with Respondent, who lived in a two-story residence in Long Beach. Respondent had a tenant who lived in the downstairs room in the house; Respondent lived in an upstairs room. Thereafter, a romantic relationship developed between Respondent and TT. TT told his family about Respondent. During one conversation with his father, TT put Respondent on the line and she identified herself as a "doctor." Respondent further told TT's father she prescribed Xanax and Ambien for TT for his mood swings.

25. In late November or early December 2007, during a call with his estranged wife, TT learned his two year old daughter was sick with a cold and high fever and put Respondent on the phone. Respondent said she was a "doctor," told TT's wife she thought the child had an ear infection, and offered to call in a prescription for the child. The wife declined the offer.

26. During November and December 2007, Respondent prescribed the following medications for TT: (1) On or about November 15, 2007, Respondent prescribed 30 tablets of Zolpidem Tartrate [Ambien], 10mg; (2) On or about November 16, 2007, Respondent prescribed

10 doses of Testosterone Cypionate 200mg/ml; (3) On or about November 22, 2007, Respondent prescribed 30 tablets of Alprazolam [Xanax], 2mg; and (4) On or about December 3, 2007, Respondent prescribed another 30 tablets of Alprazolam [Xanax], 2mg. Respondent did not perform a physical examination of TT before calling in the prescriptions, did not keep medical records of the prescriptions and their effect on TT, and did not have a supervising physician at the time.

27. On or about December 4, 2007, Respondent and TT stayed up most of the night talking and drinking. Respondent fell asleep about 0700. Respondent was awakened by her tenant knocking on the bedroom door at about 1535. Respondent unlocked and opened the bedroom door. Respondent's tenant noticed TT was lying on the floor and there were alcoholic beverage bottles lying near him. Respondent and her tenant tried to awaken TT, were unable to and noticed he was not breathing. The tenant called 911. When the officers arrived, TT was lying prone on the floor, his skin was pale, and he was deceased. In the top drawer of a nightstand, the officers found an empty prescription bottle for TT for 30 Alprazolam 2mg tablets, filled on December 3, 2007. The officers also found two empty wine bottles behind the TV set.

28. Respondent was interviewed by the police. She stated TT had been depressed and was talking about hurting himself, so she stayed up all night with him in her bedroom, consoling him, until she fell asleep. She did not discover him to be unconscious and not breathing until her roommate awakened her. She told the police she tried to revive him with CPR but was unable to.

29. During the afternoon of the day TT died, Respondent telephoned TT's former roommate, asked if he had spoken with TT recently, and then informed the roommate she had awakened, rolled over in her bed, and found TT dead on the floor beside the bed.

30. At about 1930 on the day TT died, Respondent telephoned TT's estranged wife and informed her of the death. Respondent said she left for work in the morning and TT was fine. But when she returned home in the afternoon, he was unresponsive and she was unable to resuscitate him with CPR. The next day, Respondent telephoned TT's estranged wife again and told her she and TT had fallen asleep all day and when she awoke in the afternoon, TT was unresponsive. Respondent again said she tried CPR but was not successful.

31. TT's father spoke to Respondent about his son's death, as well. Respondent told him she was awakened by knocking on her door and when she rolled over in the bed, she felt that TT was cold.

32. Sometime after TT's death, Respondent spoke with TT's mother. Respondent told TT's mother she and TT had been up all night drinking. Respondent said she fell asleep in the morning and when she awoke in the afternoon TT was unresponsive.

33. The coroner's office performed an autopsy of TT, found the death to be the result of multiple drug intoxication, and concluded the death was an accident.

Patient CM

34. On January 2, 2008, CM, TT's estranged wife, telephoned Respondent to pick up TT's belongings and asked for directions to the house. At the time, CM had a cold. Respondent said CM sounded sick and offered to call in a prescription for her. CM declined, but Respondent insisted and called in prescriptions for Promethazine with Codeine, a cough medicine, and Erythromycin, an antibiotic. Respondent did not perform an examination before calling in the prescriptions, nor did she keep a medical record for CM of the prescriptions. Respondent did not have a supervising physician at the time she prescribed the medications.

Patient AC

35. On January 7, 2008, Respondent called in a prescription for patient AC, her brother. The prescription was for 30 tablets of Xanax 1 mg. Respondent did not perform an examination before calling in the prescription, nor did she keep a medical record for AC of the prescription. Respondent did not have a supervising physician at the time she prescribed the medication.

36. On February 26, 2008, Respondent called in another prescription for 30 tablets of Xanax 1 mg. for AC. Respondent did not perform an examination before calling in the prescription, nor did she keep a medical record for AC of the prescription. Respondent did not have a supervising physician at the time she prescribed the medication.

37. Respondent practiced medicine without a supervising physician for patients TT, CM and AC, by prescribing dangerous drugs and Schedule III, IV and V controlled substances for

patients TT, CM and AC, without the required Delegation of Services Agreement, protocols, and a practice-specific formulary, as set forth in paragraphs 21, 23, 24, 25, 26, 34, 35 and 36, above.

Patient JH

38. Between April 26, 2005 and August 20, 2005, Respondent performed laser hair removal treatments on patient JH, a 43 year old woman. The treatments were done to JH's upper arm, bikini, and lower leg areas, with no ill effects.

39. On or about August 20, 2005, Respondent performed laser hair removal to JH's lower legs. At one point, the laser malfunctioned and the treatment was delayed. A technician arrived to service the machine, and once it was repaired, Respondent continued the laser hair removal on JH. Several hours after the treatment, JH informed Respondent that she was experiencing a burning sensation in her legs. Respondent recommended symptomatic treatment and also advised JH to get a dermatological consult. JH suffered burns to her legs that resulted in areas of hypopigmentation. She was treated by several laser specialists over a number of treatments with good results.

40. Respondent made no notation in JH's medical records regarding the August 20, 2005, treatment, machine malfunction, or result to JH. Respondent kept JH's medical records in a file box. Respondent misplaced JH's medical records. Respondent did not maintain JH's medical records in a supervising physician's office.

41. Respondent practiced medicine without a supervising physician, by performing laser hair removal on patient JH without the required Delegation of Services Agreement, practice protocols, and a practice-specific formulary, as set forth in paragraphs 38 and 39, above.

SECOND CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs without a Prior Examination and Medical Indication)

42. Respondent is further subject to disciplinary action under Code section 3527, subdivision (a), and CCR title 16, section 1399.521, subdivision (a), as defined by section 2242, subdivision (a), in that she prescribed dangerous drugs for patients TT, CM and AC without a prior examination or medical indication as set forth in paragraphs 23, 24, 26, 34, 35 and 36, above.

THIRD CAUSE FOR DISCIPLINE

(Violating Federal and State Statutes and Regulations Regarding Dangerous Drugs or Controlled Substances)

43. Respondent is further subject to disciplinary action under Code section 3527, subdivision (a), and CCR title 16, section 1399.521, subdivision (a), as defined by section 2238, subdivision (a), in that she violated state and federal statutes and regulations regarding dangerous drugs and controlled substances, by prescribing dangerous drugs and controlled substances for patients TT, CM and AC as set forth in paragraphs 21, 23, 24, 25, 26, 34, 35 and 36, above.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

44. Respondent is further subject to disciplinary action under Code section 3527, subdivision (a), and CCR title 16, section 1399.521, subdivision (a), as defined by section 2266, in that she failed to maintain adequate and accurate records for patients TT, CM, AC, and JH as set forth in paragraphs 23, 24, 26, 34, 35, 36, and 40, above.

FIFTH CAUSE FOR DISCIPLINE

(Dishonesty)

45. Respondent is further subject to disciplinary action under Code sections 3527, subdivision (a), and CCR title 16, section 1399.521, subdivision (a), as defined by section 2234, subdivision (e), in that she committed dishonesty substantially related to the qualifications, functions, or duties of a physician assistant. The circumstances are as follows:

A. Respondent falsely referred to herself as a "doctor," as set forth in paragraphs 22, 23, and 24, above.

B. Respondent falsely stated at her May 18, 2010, investigative interview that Dr. TB was her supervising physician, and that she discussed patient TT's night terrors and medications he had taken for the terrors with Dr. TB.

C. At her May 18, 2010, investigative interview, Respondent described the circumstances of TT's death. She stated the night of December 4, 2007, she shared wine with TT

and her tenant on the patio located off her bedroom, watched TV downstairs with her tenant, and then went upstairs to her room to work on her computer. She stated TT came to the bedroom intoxicated and made an inappropriate advance towards her. TT then asked to use the computer and Respondent agreed. Respondent stated she went downstairs and stayed up late talking with her tenant until they both fell asleep on the couch. Respondent stated at about 1:00 or 2:00 am, TT came downstairs, stated he was hungry, and left to get something at the local Jack-in-the-Box restaurant down the street from her home. Respondent did not hear TT come back because she went back to sleep on the couch. Respondent said she and her tenant awakened between 11:00 am and 1:00 pm, and went upstairs together. They found TT on the floor, with alcoholic beverages near him. Respondent checked his vital signs and began CPR, while her tenant called 911. Respondent said she continued CPR until the officers arrived. Respondent added she went up to the bedroom during the night to check on TT, and had conversations with him. Respondent's tenant denied this description of the events.

D. Respondent told more than one version of the circumstances regarding patient TT's death, as set forth in paragraphs 28 through 32, and 45.C., above.

E. Respondent falsely stated at her May 18, 2010, investigative interview that Dr. MR was her supervising physician when she was employed by Coastal Dermatology and Southland Surgical, and that she had agreements with the other physicians at Coastal, as well.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence)

46. Respondent is further subject to disciplinary action under Code section 3527, subdivision (a), and CCR title 16, section 1399.521, subdivision (a), as defined by section 2234, subdivision (b), in that she committed gross negligence, as set forth in paragraphs 21 through 41, above.

SEVENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

47. Respondent is further subject to disciplinary action under Code section 3527, subdivision (a), and CCR title 16, section 1399.521, subdivision (a), as defined by section 2234,

subdivision (c), in that she committed repeated negligent acts, as set forth in paragraphs 21 through 41, above.

EIGHTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

48. Respondent is further subject to disciplinary action under section Code section 3527, subdivision (a), and CCR title 16, section 1399.521, subdivision (a), as defined by section 2234, in that she committed general unprofessional conduct as set forth in paragraphs 21 through 41, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physician Assistant Committee issue a decision:

1. Revoking, suspending or imposing probationary conditions on Physician Assistant License Number PA 16171, issued to Tamlin Connel Santos, P.A.;

2. Ordering Tamlin Connel Santos, P.A. to pay the Physician Assistant Committee the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Ordering Tamlin Connel Santos, P.A. to pay the Physician Assistant Committee the costs of probation monitoring, if any is ordered, pursuant to Business and Professions Code section 3527, subdivision (f); and,

4. Taking such other and further action as deemed necessary and proper.

DATED: November 23, 2010

ELBERTA PORTMAN
Executive Officer
Physician Assistant Committee
Department of Consumer Affairs
State of California
Complainant